California Medi-Cal Dental Program

Denti-Cal Bulletin

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RETROACTIVE REIMBURSEMENT OF MEDI-CAL BENEFICIARIES FOR OUT-OF-POCKET EXPENSES

As a result of the *Conlan v Shewry* court decision, a process has been implemented by which beneficiaries can obtain prompt reimbursement of their Denti-Cal covered, out-of-pocket expenses, according to the terms of the decision. For questions or instructions regarding this reimbursement, please phone the Conlan Help Desk at (916) 403-2007.

Denti-Cal Responsibilities

Denti-Cal responsibilities include the following:

- Verifying beneficiary Denti-Cal eligibility
- Evaluating supporting medical expense documentation provided by the beneficiary
- Reviewing rendered services for medical necessity
- Determining whether Denti-Cal payment was previously made
- Verifying that the provider reimbursed the beneficiary
- Maintaining documentation for each case

Provider Notification of Beneficiary Request for Reimbursement

If a beneficiary's request for reimbursement is validated by Denti-Cal, a letter of request for beneficiary reimbursement is sent to the provider (see attached sample letter). This letter must be submitted with the provider's claim for reimbursement.

Provider Responsibility

Upon receipt of a beneficiary reimbursement letter, providers are expected to reimburse beneficiaries for monies that the beneficiary paid to the provider at the time of service, then submit a claim to Denti-Cal. Claims will be denied if the beneficiary has not been reimbursed.

Claim Submission

Providers must submit claims to Denti-Cal within 60 days of the date on the letter as follows:

- Submit an original hard-copy claim solely for services mentioned in the beneficiary reimbursement letter
- Attach the beneficiary reimbursement letter
- Attach any additional required Denti-Cal documentation

The original claim, beneficiary reimbursement letter, and supporting documentation should be submitted to the following address:

Denti-Cal
California Medi-Cal Dental Program
Attn: Beneficiary Services
P.O. Box 526026
Sacramento, CA 95852-6026

No electronic claim submission is allowed. *Denti-Cal determines medical necessity*, therefore no Treatment Authorization Request (TAR) is required. The six-month billing limit will be waived for these claims.

Provider Reimbursement

The reimbursement rate is the rate on file for the date of service, or if one is not listed, the current rate.

Enrollment Required for Provider Reimbursement

To be reimbursed, the provider must have been enrolled as a Denti-Cal provider on the date of service. Providers should contact Denti-Cal at (800) 423-0507 or online at www.denti-cal.ca.gov if any of the following conditions apply:

- The provider was not a Denti-Cal provider on the date of service but wants to enroll now
- The provider is a Denti-Cal provider now, but was not enrolled on the date of service and needs retroactive eligibility
- The provider was not a Denti-Cal provider on the date of service, but wants to temporarily enroll retroactively in Denti-Cal in order to bill for the Beneficiary Reimbursement Process claims.

For additional information or to answer any questions, please phone the Conlan Help Desk at (916) 403-2007.

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Date

Provider Name
Address

Correspondence Reference Number: _____

Dear Dr._____:

This letter is regarding a beneficiary reimbursement claim filed by a Medi-Cal beneficiary, _____. He/She claims they were seen in your office on mm/dd/yy & mm/dd/yy and has provided documentation of his/her payment to you in the amount of $xxx.xx.

_____was eligible for Medi-Cal on the date(s) of service listed above. As a Medi-Cal provider, you are required to reimburse the beneficiary for the payments he/she made to you for the services. The beneficiary has reported that you have not made payment to them for the amount they paid you for the service(s). In order to avoid an action by the State to withhold these funds against future payments owed to you, you must immediately make payment to the beneficiary. The payment must be for the full amount they made to you for the service(s). Once you have made payment to the beneficiary, you may submit a paper claim to Medi-Cal for reimbursement of these services. Reimbursement payment to the beneficiary should be mailed to:

Beneficiary Name
Street Address
City, CA ZIP

You must make payment to the beneficiary for the full amount of their out of pocket payment made to you. Failure to do this will result in the State taking action to withhold the funds from future payments owed to you. If you have already made full payment to the beneficiary, or if you are in the process of sending this payment, please submit proof of payment. This response should include the amount paid and the date it was paid. A response with your action must be received within 30 days from the date on the top of this letter. All correspondence should be sent to the following address:

Denti-Cal
Attention:Beneficiary Correspondence
P.O. Box 526026
Sacramento, CA 95852-6026

Billing timeliness limitations for claims submissions (pursuant to Title 42 Code of federal Regulations, section 447.45(d)(1) and California Code of Regulations (CCR), Title 22, Division 3, sections 51000.8(a) and 51008.5) will not apply due to good cause (pursuant to CCR, Title 22, Division 3, section 51008(a)) for the above claim for 60 days from the date of this letter. To request reimbursement from Medi-Cal for the services you provided, you must submit a claim within 60 days from the date of this letter. Submit an original paper claim and supporting documentation along with a copy of this letter to the following address:

Denti-Cal
Attention: Beneficiary Correspondence
P.O. Box 526026
Sacramento, CA 95852-6026

You may disagree with this decision. If you do disagree and wish to dispute this claim, you may request a State Hearing. Information for a State Hearing is on the back of this notice.

For more information on this matter, telephone the Beneficiary Service Center at (916) 403-2007. For billing assistance, call the Provider Toll-Free line at (800) 423-0507.

Sincerely,

Payment Systems Division
California Department of Health Services

Authority: Welfare and Institutions Code, Section 14019.3.

PROVIDER HEARING REQUEST FOR BENEFICIARY REIMBURSEMENT/RECOUPMENT

YOUR HEARING RIGHTS

You have a right to ask for a State Hearing about this Medi-Cal action. You must ask for a State Hearing within 30 days of the date this notice was mailed to you.

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

Denti-Cal
Attention: Beneficiary Correspondence
P.O. Box: 526026
Sacramento, CA 95852-6026

You have the right to examine the materials that were used to take this Medi-Cal action and may arrange this by contacting the Beneficiary Services at

(916) 403-2007. For TDD telephone service call (916) 635-6491.

State Regulations Available State regulations, including those covering state hearings, are available at your local county welfare office or on the Internet at www.calregs.com.

AUTHORIZED REPRESENTATIVE

You can represent yourself at the state hearing. You must provide the name, address, and phone number of the person within your business entity who will represent you prior to the hearing. You can also be represented by an attorney. You must arrange for this representative yourself.

Note: The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete.

PROVIDER HEARING REQUEST FOR BENEFICIARY REIMBURSEMENT/RECOUPMENT

☐ I would like to request a State Hearing.

The reason why I want a hearing is:

_____

_____

_____

_____

_____

☐ Check here and add a page if you need more space.

Provider name: (print)

_____

Provider Medi-Cal Number:

_____

Business Address: (print)

_____

_____

Business phone number: (_____)_____

Beneficiary Reimbursement Reference Number:

_____

☐ I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name:_____

Address:_____

_____

Phone number: (_____)_____

My signature (provider):

X_____

Date signed:

_____